

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01852

Reg. Dist. No. 253

1. PLACE OF DEATH:

County Queen Anne

City or town Stevensville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Queen Anne

City or town Stevensville
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Robert Franklin Cook

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Hellie S. Cook

8.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 27 - 1865

8. AGE: Years 80 Months 6 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Rent Is. G. A. Co. Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name John Cook

13. Birthplace England

14. Maiden name Martha Walker

15. Birthplace Queen Anne Co. Md.

18. Informant Mrs. Hellie Cook

Address Stevensville Md.

17. Burial Date thereof Feb. 18 - 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Stevensville Cem.

Location Stevensville Md.

18. Funeral director Edgar L. Lane

Address Church Hill Md.

19. Feb. 18 19 46 F. C. Thomas
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 19 46 at 11 45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 16 19 46 to Feb. 16 19 46

and that I last saw him alive on Feb. 16 19 46

Immediate cause of death _____ DURATION Feb. 16 1946

Coronary occlusion

Due to myocardial degeneration

Due to _____

Other conditions stenity

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Theodor Sattelmeyer M.D.

Stevensville M. D. or other _____

Address _____ Date signed 2/16/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 25 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH:

County Queen Anne's
 City or town Queentown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 70 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Queen Anne's
 City or town Queentown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

William Spedden Delabay

3. (b) Social Security Number

now

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Roberta Lowe Delabay

7. Birth date of deceased (mo., day, yr.)

Sept. 2 - 1856

6. (c) If alive, give age years

8. AGE:

89

Years

5

Months

22

Days

If less than one day

hrs.min.

9. Birthplace

Tolbat Co. Maryland
(Town, county and state)

10. Usual occupation

Retired Farmer &

11. Industry or business

Blacksmith

FATHER

12. Name

Thomas Spedden Delabay

13. Birthplace

Tolbat Co. Maryland

MOTHER

14. Maiden name

Arianna

15. Birthplace

Do not know, perhaps Tolbat Co.

16. Informant

Mrs. William E. Roe

Address

Centerville, Maryland

17.

Buried
(Burial, cremation, or removal, Which?)

Date thereof

July 27 - 46
(month) (day) (year)

Cemetery or crematory

Stonemansville

Location

Stonemansville, Maryland

18. Funeral director

Travis Thro

Address

Centerville, Md.

19.

Feb. 27
(Date rec'd by registrar)

19

46 Helen M. Gedridge
Loc. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24 1946 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-171946to 2-241946

and that I last saw him alive on

2-201946

Immediate cause of death

Chronic valvular disease of the heart

Due to

arteriosclerosis

Due to

chronic hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. W. H. H. H.

M. D. or other

Address

Centerville, Md.

Date signed

2/25-46

1
MAR 2 1946

BUREAU V. M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:

County Queen Anne's
 City or town Rural, Wye Mills
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? County, all his life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Queen Anne's
 City or town
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (if rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Harry Clay Faulkner

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Rue Denney Faulkner
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Nov 20 - 1874
 8. AGE: Years 71 Months 2 Days 20 If less than one day
hrs.min.

9. Birthplace Queen Anne's Co. Maryland
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Franklin Faulkner
 13. Birthplace Queen Anne's Co, Md
 MOTHER 14. Maiden name Emma Bacon
 15. Birthplace Queen Anne's Co Md

16. Informant Mrs Harry Denney
 Address Wye Mills Maryland

17. Buried Date thereof July 12 - 46
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Chesterfield
 Location Centerville Maryland

18. Funeral director Barton Bros
 Address Centerville, Maryland

19. 2-12- 19 46 Elmer Armetray
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10 1946 at 5 PM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 4 19 46 to Feb 8 19 46
 and that I last saw him alive on February 8 19 46

Immediate cause of death Myocardial infarction
RE lung

Due to Myocardial infarction
Myocardial infarction

Due to Myocardial infarction
Myocardial infarction

Other conditions Myocardial infarction
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Kurt Lederer M.D.
 M. D. or other

Address Queen Anne's Md Date signed 2/13/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

01854

RECEIVED
FEB 25 1946
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 632

CERTIFICATE OF DEATH

01856

Reg. Dist. No. 251

1. PLACE OF DEATH

County Sevier
 City or town Church Hill
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Lydell May Hadden

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Herbert Hadden

7. Birth date of deceased (mo., day, yr.)

1899 Oct 30

6. (c) If alive, give age years

8. AGE:

Years 36Months 3Days 19

If less than one day

hrs. min.

9. Birthplace

Sevier Co
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farmer

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Feb. 11 46

Edgar L. Lane

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 10 46

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 10 46

and that I last saw him alive on

Feb 10 46

Immediate cause of death

Coronary Atherosclerosis

Due to

Myocardial Infarction

Due to

Chronic Bronchitis

Other conditions

Emphysema

(Include pregnancy within 3 months of death)

Major findings of operations

None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
MAR 2 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:

County Queen Anne's
 City or town in Centerville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all the life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne's
 City or town Centerville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Jeanette Handy

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Caucasian

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

March 29 - 1932

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

131030

..... hrs.

..... min.

9. Birthplace

Centerville, 2a Co. Md

(Town, county, and state)

10. Usual occupation

school

11. Industry or business

FATHER

12. Name

James Handy

13. Birthplace

Centerville Maryland

14. Maiden name

Elysebeth Pritchett

15. Birthplace

Centerville Maryland

16. Informant

Elysebeth Pritchett Handy

Address

Centerville Maryland

17.

Buried

Date thereof

Mar. 2-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Brownsville

Location

Rural Centerville Md

18. Funeral director

Barton Bros

Address

Centerville, Md.

19.

2-28-46

19

46Elie Armstrong

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 28

19

46

at

5:30

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

Burned to death

DURATION

Due to

House caught fire

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Henry Foster 2a Co

M. D. or other

Address

Centerville Md

Date signed

2/28/46

RECEIVED

MAR 2 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH: County <u>New Anne</u> City or town <u>Grassville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>45 yrs</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>New Anne</u> City or town <u>Grassville</u> (If outside city or town limits, write RURAL and give nearest town) Street No. (If rural, give LOCATION) 2.(a) If veteran, name war.			
3. (a) FULL NAME <u>Margaret C. Lawrence</u>				3. (b) Social Security Number <u>None</u>			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Divorced</u>			
6. (b) Name of husband or wife <u>Thomas Lawrence</u>				6. (c) If alive, give age ? years			
7. Birth date of deceased (mo., day, yr.) <u>Dec 2 - 1883</u>							
8. AGE: Years <u>62</u>		Months <u>2</u>		Days <u>0</u>		If less than one day hrs. min.	
9. Birthplace <u>New Anne Co. - Md</u> (Town, county, and state)							
10. Usual occupation <u>Housewife</u>							
11. Industry or business <u>Cox</u>							
FATHER MOTHER	12. Name <u>Sarah D. Tolson</u>						
	13. Birthplace <u>New Anne Co. - Md</u>						
	14. Maiden name <u>Mrs. Nora M. Chance</u>						
15. Birthplace <u>Grassville - Md</u>							
16. Informant <u>Burke</u> Address <u>Grassville - Md</u> 17. (Burial, cremation, or removal. Which?) <u>Buried</u> Date thereof <u>Feb. 4 - 46</u> (month) (day) (year) Cemetery or crematorium <u>Centerville</u> Location <u>Centerville, Md</u> 18. Funeral director <u>Burke Bros</u> Address <u>Centerville, Md</u>							
19. (Date rec'd by registrar) <u>Feb. 4</u> 19 <u>46</u> <u> Helen M. Aldridge </u> Registrar							
MEDICAL CERTIFICATION 20. DATE OF DEATH <u>Feb 2nd</u> 19 <u>46</u> , at <u>6:30</u> A.M. 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>last</u> 19 <u>45</u> to <u>Feb 2</u> 19 <u>46</u> and that I last saw him/her alive on <u>Feb 2</u> 19 <u>46</u> Immediate cause of death <u>Coronary Arteriosclerosis</u> DURATION <u>2 mos.</u> Due to Due to Other conditions <u>Hypertension</u> <u>Sys.</u> (Include pregnancy within 3 months of death) Major findings of operations Date of op. Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE <u>Chas E Snyder</u> M. D. or other <u>Steven Snyder</u> Address Date signed <u>2/3/46</u>							

RECEIVED

FEB 13 1944

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (922)

CERTIFICATE OF DEATH

01858

Reg. Diat. No. 254

1. PLACE OF DEATH:

County Queen Anne's
 City or town Queenstown (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? one year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne's
 City or town Queenstown (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

John Vincent Little

3. (b) Social Security Number

11

4. Sex

Male

5. Color or race

Col.

6. (a) Single, married, widowed, or divorced

widowed

8. (b) Name of husband or wife

8. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Febr. 12, 1882

8. AGE:

Years

63

Months

11

Days

5

If less than one day

hrs.

min.

9. Birthplace

Grasonville, Md.

(Town, county, and state)

10. Usual occupation

farmer laborer

11. Industry or business

FATHER

12. Name

John C. Little

13. Birthplace

Grasonville, Md.

MOTHER

14. Maiden name

Sarah Marsh

15. Birthplace

Grasonville, Md.

16. Informant

Lillie Smith

Address

Queenstown, Md.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

2-9-46

Cemetery or crematory

Robinson A.M.E. Cemetery

Location

Grasonville, Md.

18. Funeral director

John D. Wilkerson

Address

Barton, Md.

19.

(Date rec'd by registrar)

19

46 Helen M. Bridge

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Febr. 7

19 46

5 A.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 10 to Febr. 7 19 46
 and that I last saw him alive on Febr. 5 19 46

Immediate cause of death

Coronary occlusion

DURATION

Febr. 7, 46

Due to

Endocarditis chronic

Several

Due to

mitral insufficiency

Glas

Other conditions

Aorta insufficiency

Decomposition

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Theodor Sattelmair M.D.

M. D. or other

Address

Harrisville

Date signed

2/7/46

RECEIVED
FEB 13 1946
BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (316)

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 1/2 yrsHospital, institution, or street address where death occurred: noHow long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Queen AnneCity or town Sunderville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Walter Marshall

3. (b) Social Security Number

4. Sex M5. Color or race W6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Lorah Hudson Marshall

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov 7 19418. AGE: Years 8 1/2 Months 3 Days 13 If less than one day _____ hrs. _____ min.9. Birthplace Del.
(Town, county, and state)10. Usual occupation Farming

11. Industry or business _____

12. Name Phyllis Marshall13. Birthplace Del.14. Maiden name Lallie Ford15. Birthplace Del.16. Informant Miss Lacey SmithAddress Frederick17. Burial (Burial, cremation, or removal, Which?) Date thereof Feb. 23, 1946
(month) (day) (year)Cemetery or crematory Odd Fellows Cem.Location Camden Delaware18. Funeral director R. B. RawlingsAddress Queensboro Ind.19. Feb. 21 1946 (Date rec'd by registrar) Edgar D. Lane Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 19 46 at 532 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from med. 19 45 to Feb 20 19 46and that I last saw him alive on Feb 19 19 46Immediate cause of death Acute Cor. Artery Disease

DURATION

Due to Chronic HypertensionDue to Chronic HypertensionOther conditions Stroke

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of _____Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE @ N. W. Utterbaugh M. D. or otherAddress Frederick Date signed 2/20/46

RECEIVED
MAR 2 1946
BUREAU V. M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01860 254

1. PLACE OF DEATH:

County Queen Anne
 City or town Queentown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all of life
 Hospital, institution, or street address where death occurred
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Queen Anne
 City or town Queentown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Cora Pinder

3. (b) Social Security Number

220-16-9822

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 B.(b) Name of husband or wife John Pinder, Deceased B.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Aug. 3 1979
 8. AGE: Years 66 Months 6 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Sudlersville, Md
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name James Pinder
 13. Birthplace Burrowsville, Md.

MOTHER 14. Maiden name Margaret Savard
 15. Birthplace Centerville, Md.

16. Informant Carris Bussae
 Address Queentown, Md

17. Burial Date thereof 2-28-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory chesterfield
 Location Centerville Md

18. Funeral director John D. Sullivan
 Address Prattville Md

19. 2-28-46 Thom M. Aedridge
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 19 46 at 12:30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 30 1946 to Feb. 26 1946
 and that I last saw him alive on Feb. 18 1946

Immediate cause of death

Acquia pectoris

Due to Coronary occlusion

Due to (Found dead in bed)

Other conditions suggest not necessary
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Theodor Sattelmeyer M.D.

Address Stevensville Date signed 2/27/46

M. D. or other

Address Date signed

RECEIVED

MAR 2 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH:

County Queen Anne's
 City or town Rural Centerville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all his life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Queen Anne's
 City or town Rural Centerville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war WW

3. (a) FULL NAME

Stanley Wilfred Porter

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Jan. 30 - 1904 6. (c) If alive, give age _____ years

8. AGE: Years 42 Months 1 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Wye Mills, Talb. Md.
 (Town, county, and state)

10. Usual occupation farm laborer

11. Industry or business _____

12. Name William J. Porter

13. Birthplace _____

14. Maiden name Daisy L. Abrams15. Birthplace Kent Co. Md.16. Informant Mary E. HammondAddress R.F.D. #3 Centerville, Md.

17. Burial Date thereof July 26 - 46
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory ChristiansburgLocation Centerville, Maryland18. Funeral director Barton BrosAddress Centerville, Maryland19. Feb. 26 19 46 John M. Adridge

(Date rec'd by registrar) Loc. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 24 19 46 at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 - 10 19 46 to 2 - 24 19 46 and that I last saw him alive on 2 - 21 19 46

Immediate cause of death _____ DURATION _____
 Due to valvular disease of the heart
 Due to acute myocardial infarction
 Duration six weeks of _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. M. Adridge M. D. or other _____Address Centerville, Md. Date signed 2/20/46

REOLIV

MAR 2 1946

BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01862

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:

County Queen Anne's
City or town Centerville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all his life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Queen Anne's
City or town Centerville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Emory Crouse Pawell

3. (b) Social Security Number

217-05-6059

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Bertha Pearl Foster

7. Birth date of deceased (mo., day, yr.) August 28 - 1887 6. (c) If alive, give age 48 years

8. AGE: Years 58 Months 5 Days 22 If less than one day hrs. min.

9. Birthplace Queen Anne's Co. Md
(Town, county, and state)

10. Usual occupation Diesel Engine operator

11. Industry or business Electric Plant

12. Name Nathan Pawell

13. Birthplace Delaware

14. Maiden name Lillie May Semmes

15. Birthplace Delaware

16. Informant Bertha Foster Pawell

Address Centerville Md

17. Buried Date thereof July 22 - 46
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Chestertown

Location Centerville, Maryland

18. Funeral director Barton Bros

Address Centerville, Md.

19. 2-21- 46 Elice Armetray
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 19 46 at 7:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death He was dead when I arrived - but from facts & history is was a heart attack
Due to Heart attack

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Henry Fisher M. D. or other

Address Centerville Md - Date signed 2-20-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 25 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:

County Queen Anne's
 City or town in Centerville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all his life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Queen Anne's
 City or town Centerville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Andrew Pritchett

3. (b) Social Security Number

218-20-5657

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Mary Bonds Pritchett5. (c) If alive, give age 51 years

7. Birth date of

deceased (mo., day, yr.)

Oct-27-1894

8. AGE:

Years

Months

Days

If less than one day

5141

hrs.

min.

9. Birthplace

Queen Anne's
 (town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Construction Work

12. Name

Edward Pritchett

13. Birthplace

Hopk. Tals. Md

14. Maiden name

Mabely Harris

15. Birthplace

Do not know

16. Informant

Address

Lucy Belle PritchettCenterville Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Mar. 2-46

(month) (day) (year)

Cemetery or crematory

Brownsville

Location

Rural Centerville. Md

18. Funeral director

Address

Barton BrosCenterville. Md

19.

2-28-46
 (Date rec'd by registrar)

19

Elise Armstrong
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 28

19

46

at

5³⁰

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19 to 19

Immediate cause of death

Pronounced to death

Due to

Due to

House caught fire

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Henry Fisher
Deputy State Examiner
 M. D. or other

Address

Date signed

Centerville Md
2-28-46

RECEIVED
MAR 2 1946
BUREAU V.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19-2

01864

CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH:

County..... Queen Anne
 City or town..... Greenstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Queen Anne

City or town..... Greenstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Thomas Robert Seward

3. (b) Social Security Number

120-12-1018-

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Fluence Seward

7. Birth date of deceased (mo., day, yr.)

Sept. 13-1886

8. AGE: Years Months Days If less than one day

59 5 21 hrs. min.

9. Birthplace

Queen Anne Co. Ind.
(Town, county and state)

10. Usual occupation

Store-keeper

11. Industry or business

12. Name

Robert Seward

13. Birthplace

Unknown

14. Maiden name

15. Birthplace

16. Informant

Mrs. Skaggs (Jenny)
Address Greenstown Ind.

17. Burial, cremation, or removal. Which?

Burial Date thereof Feb. 17-1946
(month) (day) (year)

Cemetery or crematory

Church Hill

18. Funeral director

Edgar L. Lane
Address Church Hill Ind.

19. Date rec'd by registrar

Feb. 17-1946 Registrar H. M. Ledidge

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb 15 1946 at 6 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dec 15 1945 to Feb 15 1946and that I last saw him alive on Feb 1946

Immediate cause of death.....

Chronic Interstitial Nephritis

Due to.....

Due to.....

Other conditions.....

Chronic Myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... W. Henry FraherAddress..... Centerville Ind. M. D. or otherDate signed..... 2/17-46

RECEIVED
FEB 21 1946
BUREAU 7 R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County Green AnneCity or town Rural Centerville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County Green AnneCity or town Rural Centerville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Sarah C. Stansbury

3. (b) Social Security Number

4. Sex Female 5. Color or race Wol. 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Chas. B. Stansbury6.(c) If alive, give age 63 years7. Birth date of deceased (mo., day, yr.) Nov. 17 - 18828. AGE: Years 63 Months 3 Days 3 If less than one day _____ hrs. _____ min.9. Birthplace Green Anne Co. Ind.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name Edward O. Saunders13. Birthplace Maryland14. Maiden name Rebecca Foster15. Birthplace Baltimore Ind.16. Informant Chas. StansburyAddress Centerville R. F. D.17. Burial Date thereof Feb. 24 - 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Freesville Cem.Location Freesville Ind.18. Funeral director Edgar L. LaneAddress Church Hill Ind.19. Feb. 22 19 46 Edgar L. Lane
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 19 46, at 6:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 6 19 44, to Feb 20 19 46and that I last saw him alive on Feb 17 19 46

Immediate cause of death

Circumference of uterus with moderate growth
placental, R. side wall
lesion

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations See uterus Scans
all type Date of op. May 15, 1944

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE C. P. Layton md M. D. or otherAddress Centerville Ind. Date signed 2-22-46

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF MAIL

POSTAL SERVICE

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

MAR 2 1946

BUREAU V. M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 253

1. PLACE OF DEATH:

County Queen AnneCity or town Chester
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 week

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 922 Newington Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Henry Stinson

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 9-1945

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
1 0 7 hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Seward Leonard Stinson13. Birthplace Honaker Virginia14. Maiden name Anna Thompson15. Birthplace Easton Maryland16. Informant Seward Leonard StinsonAddress 922 Newington Ave, Balto Md17. Burial Date thereof July 18-46
(Burial, cremation, or removal Which?) (month) (day) (year)Cemetery or crematory ChesterfieldLocation Centerville Maryland18. Funeral director Tracy BrosAddress Centerville, Md.19. Feb. 17 19 46 J.C. Thomas

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 19 46 at 6 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 19 46 to July 16 19 46and that I last saw him alive on July 16 19 46

Immediate cause of death

DURATION

Bronchial pneumonia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE D. Cho. E. TaylorAddress NewtonvilleDate signed 7/17/46

RECEIVED
FEB 25 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01867

CERTIFICATE OF DEATH

Reg. Dist. No. 253

1. PLACE OF DEATH:

County Green AnneCity or town Centerville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

David D. Taylor

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

a. Bertie Taylor6. (c) If alive, give age 72 years

7. Birth date of

deceased (mo., day, yr.) May 29 - 1866

8. AGE:

Years 79 Months 6 Days 27 hrs. min.

9. Birthplace

Caroline Co. Md.
(Town, county, and state)

10. Usual occupation

Retired farmer

11. Industry or business

Sec. W. Taylor

12. Name

Dr. A.

13. Birthplace

Marshall's Long

14. Maiden name

Cabling Co. Md.

15. Birthplace

Marshall's Long

16. Informant

Marshall's Long

Address

Centerville Md

17. Burial

(Burial, cremation, or removal. Which?) Mar 1 - 46
(month) (day) (year)

Cemetery or crematory

Centerville Md

Location

Centerville Md

18. Funeral director

Edgar & Lane

Address

Church Hill Md

19. 2-28-1946

(Date rec'd by registrar) Elice Armstrong
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Green AnneCity or town Centerville
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1946 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 19 1945 to Feb. 26 1946and that I last saw him alive on Feb. 20 1946

Immediate cause of death

Phemic V. V. V.Due to one of the aboveDue to Phemic V. V. V.

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

H. S. HarrisonAddress Centerville, Md. M. D. or other _____Date signed 2/28/46

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

MAR 2 1946

BUREAU OF VITALS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131a)

CERTIFICATE OF DEATH

Reg. Dist. No.

01868

553

1. PLACE OF DEATH:

County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Mary Florence Taylor

3. (b) Social Security Number

4. Sex.....

5. Color or race.....

6.(a) Single, married, widowed, or divorced.....

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....

8. AGE: Years..... Months..... Days..... If less than one day..... hrs..... min.

9. Birthplace.....
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial, cremation, or removal (Where?)..... Date thereof.....
(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar..... 19.....

Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 21, 1946, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 2, 1946, to July 21, 1946

and that I last saw him alive on July 21, 1946

Immediate cause of death.....

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....

Address..... Date signed.....

M. D. or other.....

Physician: Please underline the cause to which death should be charged statistically.

Major findings of operations.....

Date of op.....

Autopsy results.....

Physician: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....

Address..... Date signed.....

M. D. or other.....

Physician: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....

Address..... Date signed.....

M. D. or other.....

Physician: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

RECEIVED

RECEIVED

RECEIVED
FEB 27 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 124-6

CERTIFICATE OF DEATH

Reg. Dist. No. 01869 252

1. PLACE OF DEATH:

County Queen Anne'sCity or town Centerville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne'sCity or town Church Hill
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

John Wooters

3. (b) Social Security Number

4. Sex

Male

5. Color of race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Josephine Russian Wooters8. (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.)

Sept 24 - 1897

8. AGE:

Years

Months

Days

if less than one day

48516

hrs.

min.

9. Birthplace

Leviestown, Talbot Co. Md.
(Town, county, and state)

10. Usual occupation

Farm laborer

11. Industry or business

FATHER

12. Name

Gardner Wooters

13. Birthplace

Talbot Co. Md.

MOTHER

14. Maiden name

Harris

15. Birthplace

Caroline Co. Md.

16. Informant

Address

Clarence Wooters
Cadrona Maryland

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Mar 13 - 46
(month) (day) (year)

Cemetery or crematory

Spring Hill

Location

Easton, Maryland

18. Funeral director

Address

Earl W. Stoddard
Easton, Md.

19.

Mar 13 - 46
(Date rec'd by registrar)Elsie Armetrang
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 1 -1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to 19

and that I last saw him

alive on

19

Immediate cause of death

DURATION

Drowning -

Due to

Due to

Other conditions

He was found in water
3/12/46 - missing since Feb 1 - 1946
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Harry Fowler

Address

Centerville Md.Date signed 3/12/46

RECEIVED

MAR 19 1946

BUREAU